|  **REFERRAL FORM FOR BEHAVIORAL HEALTH SERVICES** |
| --- |

**Date of referral:**   **Individuals Name:**

**Phone Number:** **DOB:**

**Address:**

**Insurance Plan: Insurance ID Number:**

| **☐ Substance Use Disorder** | **☐ Mental Health** |
| --- | --- |

* **Grandview Office**

106 N. Elm St

P.O. Box 748

Grandview, WA. 98930

Ph. 509.402.9090 Fax. 1.866.974.8679

* **Kennewick Office**

100 Fruitland Rd Suite A

Kennewick, WA.

Ph . 509.581.0303 Fax. 1.866.974.8679

**Please describe circumstances for referral:**

**Referent Name:**       **Phone #:**  **Email/Fax:**